ADVANCED DENTAL GROUP

PATIENT MEDICAL INFORMATION

DATE: _____

Primary reason for today's dental appointment: ❑ Emergency ❑ Examination ❑ Consultation ❑ Hygiene appointment

DENTAL HISTORY

Please Circle

Do you have a specific Dental Problem? Describe _____	Yes No
Do you have dental examinations on a routine basis? Date of your last visit: _____	Yes No
Do you think you have active decay or gum disease? _____	Yes No
Do you brush and floss on a routine basis? _____	Yes No
Do your gums ever bleed? Describe _____	Yes No
Do you like your smile? Why? _____	Yes No
Does food catch between your teeth? Any loose teeth? _____	Yes No
Do you want to keep your remaining teeth? _____	Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____	Yes No
Have your past experiences in a dental office always been positive? _____	Yes No
Do you smoke or chew? Any sores or growths in your mouth? Discuss _____	Yes No
Name of previous Dentist (optional): _____	
Date of last full mouth X-rays (16 small films or panoramic): _____	

MEDICAL HISTORY

Are you under a physician's care now? Why? _____ Dr.'s Name: _____ Phone _____	Yes No
Have you ever been hospitalized or had a major operation? Discuss _____	Yes No
Have you ever had a serious injury to your head or neck? Discuss _____	Yes No
Are you taking any medications, aspirin, vitamins, herbals, pills or drugs? List _____	Yes No
Are you on a special diet? Discuss _____	Yes No
Are you allergic to any medications or substances? Other _____	Yes No
❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex Rubber ❑ Milk ❑ Tetracycline	
WOMEN ONLY (Please check): ❑ Pregnant/trying to get pregnant ❑ Nursing ❑ Taking oral contraceptives Discuss _____	Yes No

Do you now have or have you ever had any of the following medical conditions? Do you take any of these medications? Please check appropriate boxes
*If yes to any of the starred conditions, please call prior to your appointment . . . premedication or changes in medication may be required.

CHECK ALL THAT APPLY	Yes	No		Yes	No		Yes	No		Yes	No
Heart Problems	❑	❑	Asthma	❑	❑	Hypoglycemia	❑	❑	Alcoholism	❑	❑
High Blood Pressure	❑	❑	Bloody Sputum	❑	❑	Liver Disease	❑	❑	Tattoos/Piercings	❑	❑
Low Blood Pressure	❑	❑	Emphysema	❑	❑	Hepatitis (Any)	❑	❑	Cold Sores	❑	❑
Bacterial Endocarditis*	❑	❑	Tuberculosis	❑	❑	Protease Inhibitor	❑	❑	Fever Blisters	❑	❑
Unexplained Fever	❑	❑	Cancer	❑	❑	Night Sweats	❑	❑	Herpes	❑	❑
Bruise easy/Blood Disease	❑	❑	X-ray Treatments (Radiation)	❑	❑	Yellow Jaundice	❑	❑	Stroke	❑	❑
Anemia	❑	❑	Chemotherapy	❑	❑	Kidney Problems	❑	❑	Epilepsy or Seizures	❑	❑
Sickle Cell Disease	❑	❑	Osteoporosis	❑	❑	Thyroid Disease	❑	❑	Fainting or Dizziness	❑	❑
Hemophilia	❑	❑	Bishosphonates	❑	❑	Parathyroid Disease	❑	❑	Glaucoma	❑	❑
Methemoglobinemia	❑	❑	Aredia I.V. Reclast I.V.	❑	❑	Arthritis/Gout	❑	❑	Tumors or Growths	❑	❑
Leukemia	❑	❑	Zometa I.V.	❑	❑	Rheumatism	❑	❑	Nervousness	❑	❑
Recent Blood Transfusion	❑	❑	Fosamax, Actonel, Boniva	❑	❑	Pain in Jaw Joints	❑	❑	Psychiatric Care	❑	❑
Swelling in limbs	❑	❑	Stomach/Intestinal Disease	❑	❑	Cortisone Medicine	❑	❑	Alzheimer's Disease	❑	❑
Lung Disease	❑	❑	Ulcers	❑	❑	Artificial Joint*	❑	❑	Allergies	❑	❑
Shortness of Breath	❑	❑	Recent Weight-loss	❑	❑	Sexually Trans. Disease	❑	❑	Need Premedication?	❑	❑
Frequent Cough	❑	❑	Frequent Diarrhea	❑	❑	AIDS	❑	❑	Cochlear implants?	❑	❑
Hay Fever	❑	❑	Diabetes	❑	❑	HIV Positive	❑	❑	Other Not Listed:		
Sinus trouble	❑	❑	Excessive Thirst	❑	❑	Drug Addiction	❑	❑			

Do you wish to talk to the Dentist privately about any problem? ❑ YES ❑ No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medications change, I shall inform the Dentist and his staff at the next appointment without fail.

X _____

PATIENT SIGNATURE (PARENT OR GUARDIAN) DATE

Reviewed by Doctor _____ DATE _____ BP _____ Pulse _____

History Review and Significant Findings: _____

MEDICAL UPDATES

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions

Date	Exceptions		Patient Initials	BP	Pulse	Reviewed by
_____	_____	None ❑	_____	_____	_____	_____
_____	_____	None ❑	_____	_____	_____	_____
_____	_____	None ❑	_____	_____	_____	_____